DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Michigan Department of Community Health

☐ Medicaid ☐ CSHCS

Note: Approval refers to service only and does not authorize fees or patient eligibility, including age.

For MDCH Consultant Use Only

1. Prior Authorization No.

2	3	4	5	6	7	8	9

10. Provider Name (Last, First, Middle Initial)

11. Provider Street Address | 12. Provider County

13. City | State | ZIP Code

14. Prov. Type | 15. Provider ID No. | 16. Provider Phone No.

17. Recipient Name (Last, First, Middle Initial)

18. Recipient Street Address | 19. Birth Date

20. City | State | ZIP Code

21. Sex ☐ M ☐ F | 22. Recipient ID No. | 23. Recip. Phone No.

24. Does Patient Live in a Nursing or AIS Home? ☐ No ☐ Yes ➢ | If Yes, Facility Name | Facility Phone No.

25. Is Patient Covered by Any Other Dental Plan? ☐ No ☐ Yes ➢ | If Yes, Plan Name

26. Indicate Missing Teeth with an "X".

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

27. Are X-Rays Enclosed? ☐ No ☐ Yes ➢ | If Yes, Number of X-Rays

28. Is Treatment for Orthodontics? ☐ No ☐ Yes

29. How Long Has Patient NOT Worn a Prosthesis?

30. How Long Has Patient Been Edentulous?

31. Other Pertinent Dental or Medical History:

EXAMINATION AND TREATMENT RECORD

LINE	32. Tooth	33. Surface: M D O L I F	34. Procedure Code	35. Consultant Use Only	36. Description of Service
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37. Status of Current Prosthesis:

	Part	Full	Date Inserted	Can Be Worn Yes	Can Be Worn No	Can Be Repaired Yes	Can Be Repaired No	Used Now Yes	Used Now No
Max									
Mand									

38. Reason for Denture Replacement:

39. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Signature Date:

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40. Consultant Remarks:

41. Request Approved As:

1	5	Presented	4	8	Disapproved
2	6	Amended			No Action

42. Consultant Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought

The Department of Community Health is an equal opportunity employer, services and programs provider.

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For the Medicaid Program & Children's Special Health Care Services Mail to:

Michigan Department of Community Health
Prior Authorization – Dental
P.O. Box 30154
Lansing, MI 48909